

**LONG TERM CARE SERVICES DIVISION
STRATEGIC PLAN
FISCAL YEARS 2007-2009**



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MISSION

The Department of Mental Health – Long Term Care Services (DMH-LTCS) endeavors to support, teach and treat individuals with serious mental illness, substance addiction, disorders and forensic issues in a safe environment, so that they can fully appreciate, manage and overcome the nature and seriousness of their conditions, revive hope in their lives, recognize their strengths and power to live productive and meaningful lives in their community. DMH believes that the provision of services based on the principles of recovery and psychosocial rehabilitation values, supported by technology, offers these individuals an effective way of achieving their rehabilitation and recovery goals. DMH-LTCS is committed to implementing recovery-based psychosocial rehabilitation programs, maintaining the highest standards of care, and providing an atmosphere of creativity and continuous innovation.



VISION

The Long Term Care Services Division envisions a Hospital community in which all individuals are offered an opportunity to attain optimal physical and mental health; where mental health, freedom from addiction, and independence are recognized as health goals; where stigma and other barriers to recovery are identified and eliminated; where appropriate and effective recovery interventions are developed, delivered and continually refined; where competence is evident in the quality of services offered, and groups and activities facilitated; where relationships are built on collaboration and trust; where individuals learn new skills or learn to use existing skills in new ways to enhance the quality of their lives; and where attitudes embody the belief that a person can change, regardless of impairments, and that an individual's process of change is facilitated by support, involvement, hopefulness, and therapeutic competence of others.



CORE VALUES

The Long Term Care Services Division believes and supports the Core Values developed in 2003 by the Substance Abuse & Mental Health Services Administration (SAMHSA), President's New Freedom Commission. SAMHSA is a public health agency within the Department of Health and Human Services. The agency is responsible for improving the accountability, capacity and effectiveness of the nation's substance abuse prevention, addiction, treatment and mental health services delivery system.)

Self-Direction:

Consumers lead, control, exercise choice over, and determine their own path of recovery by optimizing autonomy, independence, and control of resources to achieve a self-determined life. By definition, the recovery process must be self-directed by the individual, who defines his or her own life goals and designs a unique path towards those goals.

Individualized & Person-Centered:

There are multiple pathways to recovery based on an individual's unique strengths and resiliencies as well as his or her needs, preferences, experiences (including past trauma), and cultural background in all of its diverse representations. Individuals also identify recovery as being an ongoing journey and an end result as well as an overall paradigm for achieving wellness and optimal mental health.

Empowerment:

Consumers have the authority to choose from a range of options and to participate in all decisions—including the allocation of resources—that will affect their lives, and are educated and supported in so doing. They have the ability to join with other consumers to collectively and effectively speak for themselves about their needs, wants, desires, and aspirations. Through empowerment, an individual gains control of his or her own destiny and influences the organizational and societal structures in his or her life.

Holistic:

Recovery encompasses an individual's whole life, including mind, body, spirit, and community. Recovery embraces all aspects of life, including housing, employment, education, mental health and healthcare treatment and services, complementary and naturalistic services, addictions treatment, spirituality, creativity, social networks, community participation, and family supports as determined by the person. Families, providers, organizations, systems, communities, and society play crucial roles in creating and maintaining meaningful opportunities for consumer access to these supports.

Non-Linear:

Recovery is not a step-by-step process but one based on continual growth, occasional setbacks, and learning from experience. Recovery begins with an initial stage of awareness in which a person recognizes that positive change is possible. This awareness enables the consumer to move on to fully engage in the work of recovery.

Strengths-Based:

Recovery focuses on valuing and building on the multiple capacities, resiliencies, talents, coping abilities, and inherent worth of individuals. By building on these strengths, consumers leave stymied life roles behind and engage in new life roles (e.g., partner, caregiver, friend, student, and employee). The process of recovery moves forward through interaction with others in supportive, trust-based relationships.

Peer Support:

Mutual support—including the sharing of experiential knowledge and skills and social learning—plays an invaluable role in recovery. Consumers encourage and engage other consumers in recovery and provide each other with a sense of belonging, supportive relationships, valued roles, and community.

Respect:

Community, systems, and societal acceptance and appreciation of consumers — including protecting their rights and eliminating discrimination and stigma—are crucial in achieving recovery. Self-acceptance and regaining belief in one's self are particularly vital. Respect ensures the inclusion and full participation of consumers in all aspects of their lives.

Responsibility:

Consumers have a personal responsibility for their own self-care and journeys of recovery. Taking steps towards their goals may require great courage. Consumers must strive to understand and give meaning to their experiences and identify coping strategies and healing processes to promote their own wellness.

Hope:

Recovery provides the essential and motivating message of a better future— that people can and do overcome the barriers and obstacles that confront them. Hope is internalized; but can be fostered by peers, families, friends, providers, and others. Hope is the catalyst of the recovery process. Mental health recovery not only benefits individuals with mental health disabilities by focusing on their abilities to live, work, learn, and fully participate in our society, but also enriches the texture of American community life. America reaps the benefits of the contributions individuals with mental disabilities can make, ultimately becoming a stronger and healthier Nation.

ETHICS, RIGHTS & RESPONSIBILITIES (RI)

GOAL

Improve the care, treatment, services and outcomes by recognizing and respecting the civil rights of each individual, by seeking and valuing and individual's input, and by conducting business in an ethical manner. Care, treatment, and services will be provided in a way that puts the needs of the individual first, respects and fosters their dignity, builds their self-esteem, and teaches them independence. With the individual's consent, encourage the support of their family and friends. With the individual's consent, include the individual's family and friends in their Wellness and Recovery Plan. In consultation with internal and external partners, establish patients' rights. Insure that these rights are protected except as necessary to ensure the safety and security of the facility, security of the individual, staff and public and provide effective treatment in the most appropriate environment.

OBJECTIVES

1. By December 28, 2007, convert the tracking system from an EXCEL Program to an ACCESS Database to more effectively manage the Headquarters Reportable Special Incident Reports (SIR's).

Responsible: Hospital Operations Chief

2. By March 31, 2008, all state hospital staff will be trained to competency in the recognition of the signs and symptoms of abuse and neglect.

Responsible: Hospital Administrators

3. By March 31, 2008, Establish and integrated Incident Management system within which incident related data from Standards Compliance Departments, Hospital Police Services/Special Investigations, and Human Resources are combined and analyzed to facilitate protection from harm. Elements include:

- Training and competency in prevention of, and recognition of signs and symptoms of, abuse and neglect
- Mechanisms for monitoring timeliness of reporting and investigation completion

- Documenting and tracking of referrals, internal and external, e.g., human resource outcomes, feedback to Patients' Rights Advocates
- Tracking and trending of relevant data toward improvement of protection from harm, e.g., staff involvement, incident type, etc.
- Revision of Special Order 227

Responsible: Enhancement Compliance Chief, Standard Compliance Directors, & Hospital Administrators

PROVISION OF CARE, TREATMENT & SERVICES (PC)

GOAL

Improve individual treatment outcomes by efficiently and effectively providing services that promote a recovery model of mental health care that is based on the assessed needs of the individual, the reduction of psychiatric symptoms and the increase of adaptive living skills. Complete person-centered and strength-based evaluations of individuals to guide treatment and provide recovery focused assessments and reports to post-hospital care providers, for civil commitment recommendations to the Courts, and to the Board of Prison Terms.

Facilitate coordination and continuity of care to pre-admission to discharge. Improve each individual's recovery outcomes by efficiently and effectively providing services that promote person-centered inclusion in Wellness and Recovery Plan and choice in services delivered.

Nursing Services staff at all hospitals will provide an average of 12-hours per week of Active Treatment Services at the Mall.

OBJECTIVES

1. By August 1, 2007, determine the timeframe for greater CONREP involvement in the discharge planning for individuals identified as nearing Community Out-patient Treatment (COT) readiness to ensure timely discharge of the individual.

Responsible: Executive Directors & Forensic Services Chief

2. By August 1, 2007, form a workgroup of the CONREP providers, CONREP Operations, and state hospitals to:
 - Identify and address system factors that act as barriers to timely discharge.
 - Develop documentation guidelines to ensure that ongoing discussion occurs between CONREP and hospital staff.
 - Develop administrative directives (ADs) and special orders (SOs) relevant to establishing a monitoring system to identify delays for state hospital referrals.

- Develop ADs and SOs relevant to convening case conferences early in the process between the hospital treatment team and the “CONREP Responsible” when disagreements arise as to the COT readiness.
- CONREP Operations and state hospital staff will commence ongoing monitoring of policy and procedures implementation at scheduled Tri-annual CONREP/Hospital meetings.

Responsible: Executive Directors & Forensic Services Chief

3. By September 30, 2007, implement a plan for the development of reliable screening tools to identify those individuals at a high risk for dysphagia.

Responsible: Enhancement Compliance Chief & Clinical Administrators

4. By October 31, 2007, develop valid and reliable integrated dysphagia assessment tool.

Responsible: Clinical Administrators & Enhancement Compliance Chief

5. By October 31, 2007, develop valid and reliable screening tool to identify individuals who are high risk for dysphagia.

Responsible: Clinical Administrators & Enhancement Compliance Chief

6. By December 28, 2007, implement screening and assessment for dysphagia of all individuals either currently residing in or newly admitted to the state hospitals.

Responsible: Enhancement Compliance Chief & Clinical Administrators

7. By January 31, 2008, implement dysphagia screening tool.

Responsible: Clinical Administrators

8. By January 31, 2008, implement dysphagia assessment tool.

Responsible: Clinical Administrators

9. By October 1, 2007, revise and implement the DMH PSR Mall Manual.

**Responsible: DMH Chief CRIPA Consultant &
Enhancement Compliance Chief**

10. By October 1, 2007, develop and begin implementing a plan to meet to meet the minimum 20 hours of active treatment for all individuals served at all hospitals during assigned PSR Mall hours.

Responsible: Clinical Administrators

11. By October 1, 2007, develop and begin implementing a plan to meet the Court Monitor's (CM) requirement that Mall services provided by the disciplines meet the following benchmarks: Psychiatry—8 hours; Psychology—10 hours; SW—10 hours; RT—15 hours; RN—12 hours; PT—12 hours; FTE Mall positions (20 hours as facilitator); and all other staff (e.g., administration, etc.)—as determined locally at each hospital.

Responsible: Clinical Administrators

12. By June 30, 2007, each state hospital will identify and develop system-wide actions to support an increased number of hours of nursing participation in the provision of Mall Services. This system will include a mechanism to monitor hours of service provision.

Responsible: Executive Directors

13. By October 1, 2007, ensure that all statewide PSR Mall monitoring tools have been developed, approved and implemented.

**Responsible: DMH Chief CRIPA Consultant &
Enhancement Compliance Chief**

14. By November 1, 2007, CONREP Operations identifies funding resource needs and develops Budget Change Proposal to implement more frequent meetings with the hospital teams and individuals nearing outpatient readiness and for more available community facilities.

Responsible: Forensic Services Chief

15. By November 30, 2007, LTCS will attend a joint workshop meeting with California Mental Health Directors Association (CMHDA) to develop a plan to decrease the number of 1370s waiting in county jail for admission to a state hospital.

Responsible: Deputy Director & Assistant Deputy Director

16. By November 30, 2007, LTCS will develop an initial 1370 screening tool for state hospitals to use upon admission to identify malingering for return to the court.

Responsible: Deputy Director & Assistant Deputy Director

17. By December 28, 2007, state hospitals will continue restraint reduction efforts and develop a proposal to transition from the use of locking restraints to unlocked restraints.

Responsible: Clinical Administrators

18. By January 1, 2008, provide additional training/education to CONREP staff on writing objective discharge criteria in the liaison reports to state hospitals.

Responsible: DMH Chief CRIPA Consultant & Forensic Services Chief

19. By June 30, 2008, assure psychosocial rehabilitation services is provided five (5) days a week for a minimum of four (4) hours a day (i.e., two hours in the morning and two hours in the afternoon each weekday) for each individual served, or two hours a day when the (adolescent) individual is in school, except days falling on State Holidays.

Responsible: Clinical Administrators

20. By June 30, 2008, fully implement the Wellness and Recovery Planning Manual of Mach, 2007.

Responsible: Clinical Administrators

MEDICATION MANAGEMENT (MM)

GOAL

Improve individual treatment outcomes by effectively and efficiently offering medication and other treatments based on scientific and biologically based assessments, evaluation and evidence-based treatment.

OBJECTIVES

IMPROVING ORGANIZATIONAL PERFORMANCE (PI)

GOAL

Long Term Care Services shall have a planned, orderly, system-wide approach to process design and performance measurement, assessments, and improvement in order to continuously improve performance and outcomes.

OBJECTIVES

1. By June 15, 2007, each state hospital shall establish a workgroup to identify the local barriers to achieving the goal of increased nursing staff participation at the Mall.

Responsible: Executive Directors

2. By July 30, 2007, develop action steps to resolve identified barriers to support increased number of hours of service provision in Malls by Nursing Services staff.

Responsible: Executive Directors

3. By September 30, 2007, develop a system to track status of all Special Orders and state hospital Administrative Directives needing revision, or newly developed in response to the Division's Strategic or Enhancement Plan.

Responsible: Enhancement Compliance Chief

4. By December 28, 2007, establish a mechanism to evaluate the compliance and quality of the Seclusion & Restraint Debriefing Process as identified in Special Order No. 119.

**Responsible: Clinical Administrators &
Standards Compliance Coordinators**

5. By December 28, 2008, in collaboration with the California Justice Project, state hospitals will develop a plan to increase the use of video-conferencing for an individual's medication hearings.

Responsible: Hospital Operations Chief

6. By February 28, 2008, extensive WIC 7301 Training will be provided to DMH and CDCR staff to ensure oversight and consultation related to mental health needs with DMH hospitals and psychiatric programs.

Responsible: Correctional Services & Support Chief

7. By April 2, 2008, revise and distribute the Division of Juvenile Justice (DJJ) and California Department of Corrections & Rehabilitation (CDCR) Memorandums of Understanding.

Responsible: Correctional Services & Support Chief

8. By May 1, 2008, complete training of the Division of Juvenile Justice (DJJ) and California Department of Corrections & Rehabilitation (CDCR) Memorandums of Understanding.

Responsible: Correctional Services & Support Chief

9. By July 1, 2007, finalize and implement a statewide system for monthly reporting of each hospital's EP compliance data to the Executives Directors, DMH Consulting Psychologist, DMH Chief CRIPA Consultant, and the CRIPA Business Manager.

Responsible: Standards Compliance Coordinators

10. By September 1, 2007, develop and implement a statewide system for tracking and trending the data hospitals' monthly compliance data, with systems implications.

Responsible: Standards Compliance Coordinators

11. By July 1, 2007, each hospital will develop and begin implementation of a plan for tracking, trending, and using local Key Indicator data for changes in policies, processes and practices.

Responsible: Standards Compliance Coordinators

LEADERSHIP (LD)

GOAL

Maintain our role as recognized state and national leaders on issues affecting persons with mental illness while working towards a more effective mental health system that values recovery, hope and excellence and ensure that the State-Authorized Risk Assessment Tool for Sex Offenders (SARATSO) reflects the most reliable, objective and well-established protocols for predicting sex offender risk recidivism, has been scientifically validated with multiple cross-validations, and is widely accepted by the courts.

OBJECTIVES

1. By July 1, 2007, research risk assessment tools for females required to register as sex offenders.

Responsible: Sex Offender Commitment Program Chief

2. By July 1, 2007, develop plan for the independent review of every new and revised PBS plan, for adherence to the principles of PBS.

Responsible: Psychology Chiefs

3. By July 1, 2007, develop a plan for HQ to assume a stronger oversight role and function as the hospitals come into compliance with the EP as the Court Monitor's role diminishes.

Responsible: Enhancement Compliance Chief

4. By July 1, 2007, ensure that all statewide WRP monitoring tools have been developed, approved and implemented.

**Responsible: DMH Chief CRIPA Consultant &
Enhancement Compliance Chief**

5. By August 30, 2007, each HQ Chief will provide a succession plan to identify and train a back-up and to cross-train within their branch.

Responsible: HQ Chiefs

6. By August 30, 2007, each state hospital and psychiatric program will provide a succession plan to identify and train back-ups for their Executive Teams, Department Heads and Program Managers.

Responsible: Executive Directors

7. By September 28, 2007, revise and implement the DMH PBS Manual.

Responsible: Psychology Chiefs, DMH Chief CRIPA Consultant & Enhancement Compliance Chief

8. By September 28, 2007, develop appropriate BCP for the appropriate staff and resources to implement oversight plan.

Responsible: Enhancement Compliance Chief

9. By October 1, 2007, develop and initiate a plan for full implementation of the DMH WRP Manual including:

- Initial and Integrated Assessments,
- A-WRP
- Timelines for WRP conferences, and
- Consistent and enduring WRP teams
- Full participation of individuals in the WRPC

Responsible: Clinical Administrators

10. By November 30, 2007, LTCS will develop a draft plan for the phase-in of a staffing matrix model to restructure the delivery of staff consistent with the requirements of the CRIPA Enhancement Plan that provides the necessary managerial/supervisory reporting lines for Medical, Clinical, and Administrative service areas for presentation to control agencies, i.e., Agency, State Personnel Board, Department of Personnel Services, and Department of Finance.

Responsible: Assistant Deputy Director

11. By January 1, 2008, collaborate with the DMH Chief CRIPA Consultant, to develop and implement a system-wide PBS system.

Responsible: Psychology Chiefs & Enhancement Compliance Chief

12. By March 30, 2008, with approval of the draft plan for development of the new staffing matrix, LTCS will notice the necessary bargaining entitles to implement phase one of the staffing matrix model to appropriately reflect the identified reporting lines and newly developed classifications as required within the Medical area for consistency with the Enhancement Plan requirements.

Responsible: Assistant Deputy Director

13. By June 29, 2008, revise the Preventative Management of Assaultive Behavior Manual (PMAB) to incorporate Wellness and Recovery Principles. Components of the Wellness and Recovery Principles that will be included in the PMAB Manual will be:

- Individual debriefing
- Verbal de-escalation
- Identification of incident
- Aggression Type
- Procedures Containments; and
- Application of restraints that are state-of-the art

Responsible: Enhancement Compliance Chief

14. By July 1, 2008, DMH to administer the SARATSO to every PC 290 offender committed to the Department.

Responsible: Sex Offender Commitment Program Chief

15. By August 1, 2007, all state hospitals will analyze and identify the membership of the Executive Team.

Responsible: Executive Directors

MANAGEMENT OF THE ENVIRONMENT OF CARE (EC)

GOAL

LTCS Management will plan for and provide appropriate housing, treatment space, and replacement of infrastructure to provide a safe, secure, accessible and energy efficient environment for all individuals, staff, and visitors. Provide continual mental health care to California Department of Corrections and Rehabilitation (CDCR) inmates. DMH will successfully transition state hospitals from allowing cigarette smoking on campus, to banning any tobacco products from hospital property thereby promoting a healthier, safer environment for all individuals that resides, work and visit the facility.

OBJECTIVES

1. By May 30, 2007, Napa State Hospital's Tobacco-Free Transition Team will collect baseline data for outcome measures. Data may include:

- Number of individuals who smoke
- Number of Staff who smoke
- Amount of profits from tobacco products sold at Our Café stores
- Number of individuals who sue inhalers/nebulizers,
- An individual's weight,
- Number of fires related to smoking or stinger use,
- Number of behavior incidents related to smoking,
- Hours of CIO, and
- Incidents of Seclusion and/or Restraints

Responsible: Napa State Hospital Executive Director

2. By September 1, 2007, Napa State Hospital will develop a plan to transition to a Tobacco-Free environment.

Responsible: Napa State Hospital Executive Director

3. By February 1, 2008, Napa State Hospital will begin implementation of their Tobacco-Free Transition Plan.

Responsible: Napa State Hospital Executive Director

4. By September 1, 2007, Atascadero and Patton State Hospitals will begin implementation of their Tobacco-Free Transition Plan.

**Responsible: Atascadero State Hospital Executive Director,
Patton State Hospital Executive Director**

5. By May 31, 2007, submit a Budget Change Proposal (BCP) to request field staff to consult and collaborate with CDCR in the design and building of an additional 1,300 mental health beds at the DMH psychiatric programs (SVPP, VPP and CSP/SAC). The BCP will also request additional HQ staff to address the significant increase in the roles and responsibilities of the Correctional Services & Support (CS&S) Unit.

Responsible: Correctional Services & Support Chief

6. By June 5, 2007, Salinas Valley Psychiatric Program will develop a staffing package to activate a second 64-bed Level IV Intermediate Care Treatment Program freestanding facility.

**Responsible: Salinas Valley Executive Director
& Correctional Services & Support Chief**

7. By July 16, 2007, Salinas Valley Psychiatric Program will develop a Budget Change Proposal to activate a second 64-bed Level IV Intermediate Care Treatment Program freestanding facility.

**Responsible: Salinas Valley Executive Director
& Correctional Services & Support Chief**

8. By June 30, 2008, the Vacaville Psychiatric Program will collaborate with CDCR to develop construction plans for a 64-bed Level IV Intermediate Treatment Program.

**Responsible: Vacaville Psychiatric Program Executive Director
& Corrections Services & Support Chief**

9. By August 1, 2007, the Correctional Services and Support Unit will complete the procedure manual to provide a comprehensive overview of the functions and responsibilities of the unit.

Responsible: Correctional Services & Support Chief

10. By September 30, 2007, submit a draft negotiated contract to an identified vendor for 40 IST beds.

Responsible: Program Policy & Fiscal Support Chief

11. By October 31, 2007, finalize a plan to occupy the 40 IST beds.

Responsible: Program Policy & Fiscal Support Chief

12. By December 28, 2007, develop a plan to increase state hospital secure bed capacity to assist with the management of the growing forensic population.

Responsible: Hospital Operations Chief

13. By December 28, 2007, Salinas Valley Psychiatric Program will receive Position Authority and Funding to activate a second 64-bed Level IV Intermediate Care Treatment Program freestanding facility.

Responsible: Salinas Valley Executive Director

14. By July 1, 2009, Salinas Valley Psychiatric Program will finalize the operational manuals for the second 64-bed Level IV Intermediate Care Treatment Program freestanding facility.

Responsible: Salinas Valley Executive Director

15. By June 30, 2008, complete the Health & Safety related Environmental Special Repairs that are identified within the CRIPA Budget Change Proposal (BCP) and the Governor's Budget for FY 2007-2008.

Responsible: Executive Directors & Hospital Operations Chief

16. By January 1, 2008, determine whether the STATIC-99 should be supplemented with an actuarial instrument that measures dynamic risk factors or whether the STATIC-99 should be replaced as the SARATSO with a different risk assessment tool.

Responsible: Sex Offender Commitment Program Chief

17. By January 1, 2008, develop in consultation with specified entities, a training program for persons authorized to administer the SARATSO.

Responsible: Sex Offender Commitment Program Chief

18. By January 1, 2008, research providing a means by which a PC 290 offender may be assessed earlier than scheduled, at his or her own expense.

Responsible: Sex Offender Commitment Program Chief

19. By January 15, 2008, introduce legislation to implement the plan and schedule for assessing PC 290 offenders not subject to assessment by CDCR, DMH or Probation.

Responsible: Sex Offender Commitment Program Chief

20. By September 1, 2007, identify CONREP Providers willing and able to increase their case load capacity.

Responsible: Forensic Services Chief

21. By November 1, 2007, complete staff analysis of proposed program expansion with Identified CONREP Providers.

Responsible: Forensic Services Chief

22. By January 1, 2008, Forensic Services will have completed contract negotiations to fund increased case load capacity.

Responsible: Forensic Services Chief

MANAGEMENT OF HUMAN RESOURCES (HR)

GOAL

Provide qualified, professional, and competent staff in an environment that respects, involves, provides appropriate training and creates opportunities for all employees and design and implement an organizational structure that facilitates the efficient and effective utilization of human resources, consistent with the treatment enhancement plan. DMH will bring Psychosocial Rehabilitation training and certification to state hospitals and psychiatric programs.

OBJECTIVES

1. By December 28, 2007, DMH will make contact with United States Psychiatric Rehabilitation Association (USPRA) to determine:
 - Steps DMH should undertake in order to have the Certified Psychiatric Rehabilitation Professional (CPRP) certification be recognized in California
 - Recommendations to bring Psychosocial Rehabilitation (PSR) training to California which is comparable to the PSR programs offered at Boston University and the University of Medicine and Dentistry New Jersey (UMDNJ)
 - Establishing an alliance between USPRA and DMH

Responsible: Enhancement Compliance Chief & DMH Personnel Officer

2. By September 30, 2007, DMH will attend or have made arrangements to attend the Training Advisory meetings of the Chancellors of the California University, State University and Community College System to:
 - Present an overview of the President's New Freedom Commission stance on mental health care
 - Identify the need for Recovery Model/Psychiatric Psychosocial Rehabilitation training within the Professional and Healthcare Departments of the universities and community college programs
 - Establish an alliance with the university system such that a university in northern California and a university in southern California become training sites for PSR training analogous to the training provided at Boston

University and the University of Medicine and Dentistry in New Jersey. Training would involve staff from County Mental Health and DMH Long Term Care facilities

- Identify the need for Certification Training, degree opportunities for Associate, Bachelor, Masters and Doctorate degrees in the PSR field
- Identify opportunities for consumers to receive training and obtain the PSR certification analogous to Boston University and USPRA.

Responsible: Hospital Administrators & Clinical Administrators

3. By September 30, 2007, discussions will be held with DMH Human Resources Office, Executive Directors and the State Personnel Board (SPB) to encourage the CPRP certification for "Range B" pay, or to discuss other criterion needed for a promotion track.

**Responsible: Hospital Administrators
& Patton State Hospital Executive Director**

4. By September 1, 2007, discuss computer sites for each of the State Hospitals for taking the CPRP certification exam on-line.

**Responsible: Hospital Operations Chief, Hospital Administrators
& Patton State Hospital Executive Director**

5. By October 1, 2007, DMH will provide a supportive statement encouraging DMH employees to obtain the CPRP certification.

**Responsible: Executive Directors, Hospital Administrators
& Patton State Hospital Executive Director**

6. By October 1, 2007, a link to the DMH website will be added which would allow staff to pursue independent learning about obtaining a CPRP certification and a list of colleges or universities who offer training, education or degrees in PSR.

**Responsible: Hospital Operations Chief, Hospital Administrators
& Patton State Hospital Executive Director**

7. By September 30, 2007, the Department will review and make recommendations as to potential use of video conferencing technology within and between other entities to maximize resources and expertise across the Department.

Responsible: Hospital Operations Chief & Hospital Administrators

8. By November 30, 2007, each state hospital and psychiatric program will develop a monitoring/tracking system to provide consistent reporting of all recruitment efforts made including the tracking of any contract personnel for the delivery of personnel services within their specific facility. This is consistent with the recommendations of the recruitment contractor for monitoring and oversight.

**Responsible: Executive Directors, Deputy Director
& Assistant Deputy Director**

9. By August 30, 2007, LTCS will be a participant in the Department of Personnel Administration and Human Services Agency Advisory Council for Recruitment of Health & Mental Health Professionals to hire a recruitment contractor and provide direction and oversight in establishment of a consistent recruitment pool of mental healthcare professionals specific to the needs of DMH state hospitals and psychiatric programs.

Responsible: Deputy Director & Assistant Deputy Director

10. By December 28, 2007, each DMH state hospital will review and modify their strategic plans to incorporate the Long Term Care Services (LTCS) Cultural Competence Plan adopted in 2002 into the implementation of their recovery enhancement efforts.

Responsible: Office of Multicultural Services Chief

MANAGEMENT OF INFORMATION (IM)

GOAL

Obtain, manage, and use information to improve the performance of the LTCS Division, its program, hospitals, and staff in individual care and support services.

OBJECTIVES

1. By June 29, 2007, identify automation and information management needs of state hospital dental offices. Develop a plan and timetables for procurement and support of any automation software purchased or developed.

Responsible: Medical Directors & Enhancement Compliance Chief

2. By September 28, 2007, DMH will have the ability to submit billing to Medicare Prescription Drug Plans for reimbursement of medication costs.

**Responsible: Program Policy & Fiscal Support Chief
& Headquarters IT Staff**

3. By September 28, 2007, develop a process which will give each state hospital the ability to enter necessary information into the ADT and CRS Systems.

**Responsible: Program Policy & Fiscal Support Chief
& Headquarters IT Staff**

ENTERPRISE NETWORK INFRASTRUCTURE

4. By June 30, 2008, assess options and costs for secure wireless local area network connectivity including telecom redundancy and remote use of Smart Phones and laptops.

Responsible: Headquarters & State Hospital IT Managers

5. By January 31, 2008, complete the tasks necessary to be in compliance with HIPAA and DOF security requirements. Tasks include: upgrade all operating systems to XP, deploy software encryption tool, deploy network auditing tool, deploy email encryption tool and automate all security patch updates.

Responsible: Headquarters & State Hospital IT Managers

6. By April 30, 2008, align local area network environment with the DMH IT Infrastructure standards as outline in the DMH Desktop and Mobile Computing Policy. Tasks include: migrate from Novell to Microsoft, upgrade all software and hardware to meet specified standards and deploy Citrix and thin client technology to secured areas.

Responsible: Headquarters & State Hospital IT Managers

7. By July 31, 2008, migrate email messaging system from GroupWise to Exchange. Modify email address format to align with DMH standard email address format (firstname.lastname@ash.dmh.ca.gov).

Responsible: Headquarters & State Hospital IT Managers

APPLICATIONS

8. By June 29, 2007, perform Network/Telecom Assessment of each hospital network to gain an understanding of network configuration and telecom usage to improve system response time. Procure additional telecom lines and networking hardware and software products as deemed necessary at each hospital.

Responsible: Headquarters & State Hospital IT Managers

9. By July 31, 2008, HQ IT will develop and implement a new system, with a central data repository for providing and maintaining information related to Sexually Violent Predators.

**Responsible: Headquarters IT Staff
& Sex Offender Commitment Program Chief**

10. By September 1, 2007, convert the Coordinated Clinical Assessment Team (CCAT) EXCEL database to Access.

Responsible: Correctional Services & Support Chief

11. By May 30, 2008, assess various options for hospital backup lines, then procure, configure, install, and test to ensure uptime 24 hours a day, 7 days a week 365 days a year (24/7/365).

Responsible: Headquarters & State Hospital IT Managers

12. By September 28, 2007, implement the Medicare Modernization Act Part D Process to provide eligible individuals billing and reimbursement collection from Prescription Drug Plans (PDP's).

**Responsible: Program Policy & Fiscal Support Chief
& Headquarters IT**

13. By June 30, 2008, implement the new Software AG Event Replicator product to increase data integrity and replace current HCO/ODS processes.

Responsible: Headquarters & State Hospital IT Managers

14. By June 30, 2008, Coalinga State Hospital will install a Document Management System that will facilitate transfer of SVP evaluations between HQ and Coalinga State Hospital.

Responsible: Hospital Administrator & Coalinga State Hospital

GENERAL

15. By December 31, 2007, all state hospitals will submit Special Incident Reports (SIRs) briefs via the Information Technology Web Services (ITWS) System.

**Responsible: Standards Compliance Coordinators
& Hospital Operations Chief**

SURVEILLANCE, PREVENTION & CONTROL OF INFECTION (IC)

GOAL

Decrease the potential for the spread of, at a minimum, Hepatitis B and Varicella in DMH facilities. (Other vaccine-preventable diseases may be added depending on clinical/epidemiologic data and the availability of resources.)

OBJECTIVES

SECURITY

GOAL

Acquire, manage and provide information necessary to measure, monitor, and improve performance regarding internal and perimeter security practices for the purpose of providing a safe and secure treatment environment for individuals, and staff, and to protect the surrounding community at each state hospital location and focuses on multiple systems that provide a safe and therapeutic environment systems including thorough policies and procedures, sound communication structures, alert systems, secure physical spaces and perimeters, and skilled treatment and protective staff.

OBJECTIVES

1. By January 1, 2008, ensure that each state hospital has fully and effectively implemented procedures providing a safe and secure environment for CONREP staff. Elements to be included in the project shall be:
 - Form a workgroup consisting of staff from CONREP, CONREP Operations and state hospitals,
 - Review and update hospital security policies and procedures to ensure they meet safety needs of CONREP staff and are uniformly implemented across all units within each hospital,
 - Distribute reminder memos annually from Community Forensic Liaison (CFL) Office to Program Directors and Service Chiefs regarding safety procedures for CONREP staff, and
 - Review hospital safety procedures for CONREP staff annually at scheduled Tri-Annual CONREP/State Hospital Meetings.

Responsible: Executive Directors & Forensic Services Chief

2. In accordance with Special Order 247.03, annual security audits will take place at all state hospitals. Depending on the specific needs assessments of the hospitals, the audits will be either full or focused in nature.

Responsible: Hospital Security & Safety Chief

3. Within thirty (30) days of the completion of the security audits a comprehensive Plan of Correction, including completion dates, will be required for all areas in need of improvement. The Plan of Correction will be sent to the Deputy Director of Long Term Care Services for review and approval. Follow-up Compliance Reviews of the Corrective Action Plans may be conducted by the Chief, Hospital Security and Safety.

Responsible: Executive Directors & Hospital Security & Safety Chief

MANAGEMENT OF FISCAL RESOURCES (FR)

GOAL

Provide continuous improvement of fiscal systems, processes and reporting requirements.

OBJECTIVES

1. During 2007 (*as reported*), each state hospital will maintain a 3 percent or lower average Medicare error rate for all reported Office of the Inspector General (OIG) related categories (doctor did not see individual, insufficient documentation, and miss coded) as measured by internal and external audits.

**Responsible: Executive Directors &
Program Policy & Fiscal Support Chief**

2. By June 30, 2007, all state hospitals will be in compliance with Special Order, #257, Medicare Part D by providing an ICD 9 Code/DSM IV diagnosis on all medication orders. (Refer to SO, #257, IV. Prescribing Practices, Section B).

Responsible: Medical Directors

3. Annually, Program Policy & Fiscal Support will audit all state hospitals to ensure -compliance with ICD 9 Code/DSM IV diagnosis on all medication orders.

Responsible: Medical Directors & Program Policy & Fiscal Support Chief

ACRONYMS USED IN THE LONG TERM CARE STRATEGIC PLAN

AD	Administrative Directive (state hospital policy)
A-WRP	Admission – Wellness and Recovery Plan
BCP	Budget Change Proposal
CDCR	California Department of Corrections and Rehabilitation
CIO	Close In-sight Observation
CM	Court Monitor
CMHDA	California Mental Health Directors Association
CONREP	Conditional Release Program
COT	Community Out-patient Treatment
CRIPA	Civil Rights of Institutionalized Persons Act
CS&S	Correctional Services and Support
CSP/SAC	California State Prison/Sacramento
DJJ	Department of Juvenile Justice
EP	Enhancement Plan
FTE	Full-time Employee
HCO/ODS	Hospital Clinical Operations/Operational Data Store
LTCS	Long Term Care Services
PC 1370	Incompetent to Stand Trial
PBS	Positive Behavioral Support
PDP	Prescription Drug Plan
PMAB	Preventive Management of Assaultive Behavior
PSR	Psychosocial Rehabilitation
PT	Psychiatric Technician
RN	Registered Nurse
RT	Recreation Therapy
SAMHSA	Substance Abuse and Mental Health Services Administration
SARATSO	State Authorized Risk Assessment Tool for Sex Offenders
SO	Special Order (Long Term Care Services policy for state hospitals)
SVP	Sexually Violent Predator
SW	Social Work Monitoring Tool
VPP	Vacaville Psychiatric Program
WIC	Welfare and Institutions Code
WIC 7301	Individual Transferred to Institution Under Jurisdiction of California Department of Corrections and Rehabilitation
WRP	Wellness and Recovery Plan